**PLEASE NOTE: IT IS VERY IMPORTANT THAT THE FRONT DESK IS NOTIFIED IMMEDIATELY IN REGARDS TO ANY CHANGES IN DETAILS. THANK YOU.**

Have you previously seen Dr Sleeman or Dr Bowditch before? Yes ☐ No ☐

Mrs/Miss/Ms/Mr (please circle) Surname:……..……...

Given names:……Previous/Maiden name:……..
(First name) (Middle name)

Preferred name:……

Residential Address:……..Town:…..……P/Code:….……

Postal Address:……..Town:……..P/Code:……..

Telephone: H)……..W)……..M)…….

Date of Birth:…….. Email:…….

Husband/Partner/Defacto/Wife……
(Please circle) (Surname) (Given name)

Medicare card number Expiry date:___/___/20___

| | | | | | | | | | | Reference number (the number in front of your name) | |
|---|---|---|---|---|---|---|---|---|---|---|---|

Pension ☐ Health care card: ☐ Expiry date:___/___/20___

| | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|

Usual Doctor (GP):……..……Referring Doctor:……..……

Do you have private health insurance that covers you for a stay in the :( please tick which is applicable)
Private Hospital? ☐ Base Hospital? ☐

Name of Health Fund:……

Membership number:……..Level of Cover:……..

Emergency contact person:…….

Relationship to patient:……...

Telephone: H)……..W)……M)…….

**Payment of account and account responsibility**. This Practice is a Private Practice and accounts will be issued. A discount is available on accounts paid at the time of consultation. The account is partly rebatable from Medicare. Overdue accounts are subject to an administration fee and all patients may be subject to a credit check.

Accounts may also be received from Anatpath, Victorian Cytology and/or a local pathology provider if a smear, histology or blood test are taken and sent for assessment.

**"I understand and agree to pay all accounts to the practice of Dr Sleeman".**

Signed:(person responsible for account)……

Name:(please print)…… Date:…./…../……...